Trauma Verification Q&A Web Conference

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COTVRC@facs.org
Your Trauma Quality Programs Staff

Tammy Morgan
Manager
Trauma Center Programs

Molly Lozada
Program Manager
Trauma Verification

Rachel Tanchez
Site Visit Coordinator
Trauma Verification

Megan Hudgins
Program Coordinator
Trauma Verification
Continuing Education (CE)

- To qualify for CE, you must attend at least 50 minutes of educational content

- An email will be sent to all attendees who qualify for CE within 24 hours of the webinar ending, with instructions on how to claim CE

- If you have any questions – please email COTVRC@facs.org
What is the goal for this Webinar?

- Interpret the standards outlined in the Resources for Optimal Care of the Injured Patient manual to ensure that hospitals have an understanding of the criteria to provide quality care to the injured patient.

- Understand the processes and standards involved in an ACS Trauma Verification Site Visit and how following these will positively impact the quality of care of the injured patient at your center.
Let’s get started!
Orange Resources Book

Available as hard copy or PDF version, it is recommended that you have it available as reference during the **CD-Related Questions** section of this webinar.

**Must use the most current Clarification Document and the Verification Change Log in conjunction with the manual.**

www.facs.org/quality-programs/trauma/vrc/resources
Clarification Document and Verification Change Log

- Released Monthly
- Change Log – notes criteria updates/changes
- Available and download: www.facs.org/quality-programs/trauma/vrc/resources

<table>
<thead>
<tr>
<th>Chapter</th>
<th>CD #</th>
<th>Level I</th>
<th>Level II</th>
<th>Level III</th>
<th>Level IV</th>
<th>PTC I</th>
<th>PTC II</th>
<th>Date Change</th>
<th>Criteria</th>
<th>Resources 2014 Orange Book Description of Criteria</th>
<th>Clarification</th>
<th>Type</th>
</tr>
</thead>
<tbody>
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<td>1</td>
<td>1-1</td>
<td>I</td>
<td>II</td>
<td>III</td>
<td>IV</td>
<td>I</td>
<td>II</td>
<td>7/1/2014</td>
<td>New</td>
<td>The individual trauma centers and their health care providers are essential system resources that must be active and engaged participants (CD 1-1)</td>
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<td>They must function in a way that pushes trauma center–based standardization, integration, and PIPS out to the region while engaging in inclusive trauma system planning and development (CD 1-2)</td>
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<td>Meaningful involvement in state and regional trauma system planning, development, and operation is essential for all designated trauma centers and participating acute care facilities within a region (CD 1-3)</td>
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<td>7/1/2014</td>
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<td>This trauma center must have an integrated, concurrent performance improvement and patient safety (PIPS) program to ensure optimal care and continuous improvement in care (CD 2-1).</td>
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<td>7/1/2014</td>
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<td>Surgical commitment is essential for a properly functioning trauma center (CD 2-2).</td>
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<td>7/1/2014</td>
<td>New</td>
<td>Trauma centers must be able to provide the necessary human and physical resources (physical plant and equipment) to properly administrate acute care consistent with their level of verification (CD 2-3).</td>
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<td>2</td>
<td>2-5</td>
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<td>II</td>
<td>7/1/2014</td>
<td>Revised</td>
<td>Through the trauma PIPS program and hospital policy, the trauma director must have responsibility and authority for determining each general surgeon’s ability to participate on the trauma panel based on an annual review (CD 2-5).</td>
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Website Resources for Trauma Centers

• Recording of Webinars: https://www.facs.org/quality-programs/trauma/vrc/resources/webinars

• Stakeholder Public-Comment website: https://www.facs.org/quality-programs/trauma/vrc/public-comment

• Frequently Asked Questions (FAQs): https://www.facs.org/quality-programs/trauma/vrc/faq

• Tutorials:
  • Becoming a Verified Trauma Center: First Steps
  • Becoming a Verified Trauma Center: Site Visit: https://www.facs.org/quality-programs/trauma/vrc/resources

• Participant Hub - Account Center: https://www.facs.org/quality-programs/trauma/tqp/tqp-center
Disclaimer

• All questions are pulled directly from the question submissions. There have been no edits made to the contents.

• If your question is not answered today, the question may require more information, and will receive a response from ACS staff within one week after the webinar.
Announcements
Next Verification Q&A Webinar

Webinar Date: **Wednesday, September 19th**

Webinar Time: **12:00 PM Central Time**

Deadline to submit questions: **Thursday, September 6th**
Hotel reservations are now open
Preconference Workshop Registration is now open:
www.facs.org/quality-programs/trauma/tqip/meeting
<table>
<thead>
<tr>
<th>Wednesday, November 14</th>
<th>Thursday, November 15</th>
<th>Friday, November 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIS15 and Injury Scaling Uses and Techniques</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOPIC</strong></td>
<td><strong>Optimal Course</strong></td>
<td></td>
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<td></td>
<td>Bleeding Control Basics</td>
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<td>Sharper Coding for Trauma w/ICD-10 &amp; ICD-10-PCS</td>
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<td>TCRN Preparatory and Faculty Training Course</td>
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<td>Trauma Advanced Registrar Prep</td>
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<td>Trauma Registry Course</td>
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https://www.facs.org/quality-programs/trauma/tqip/meeting/workshops
NTDB Call for Data

• The ACS COT Annual Call for Data is now open and will end October 1, 2018. During this call, we are accepting Admission Year 2017 Data. TQIP Participants are not expected to participate in this call for data and should follow their regular quarterly data submission schedule.

• Centers with upcoming Consultation or Verification visits will not have to pay to submit data.

• For more information or to begin the process of joining the Annual Call for Data, please visit our website: https://www.facs.org/quality-programs/trauma/ntdb/cfd-instructions.
PRQ Updates & Questions
PRQ – Facility Treats What Type of Patients

Facility treats what type of patients is not based on the type of visit the center is having. It is based on the type of patients that were admitted during the reporting year.

- **Adult Only** - facilities that did **not** admit children during the reporting year.
- **Adult + Children** – all facilities that admitted children during the reporting year, regardless of the number, and is seeking or is not seeking pediatric verification, must select this type of patients during the online application process, and must complete section X. Pediatric Trauma as noted in the PRQ.

- If this is currently blank or incorrect in your online PRQ, please contact the VRC office at COTVRC@facs.org.
Level III Neurosurgery Capabilities

For Level III trauma centers the following question must be marked as either ‘Yes’ or ‘No’

• Does the Level III center provide Neurosurgery Capabilities?

If this is not marked as either, please contact the VRC office at COTVRC@facs.org.
CME for all Specialties & Appendices

- Updates have been completed to the online PRQ.

- The PRQs in Word have also been updated on the webpage as of 8/23/18.
  
  - If a copy was downloaded prior to the date above, the CME questions will appear, just skip over those as they will not appear in the online PRQ.

- For Level I and II trauma centers, in the appendices only enter the CME for the Adult and/or Pediatric Trauma Medical Director (TMD) and anyone who is new or has previously been approved for the Alternate Pathway (AP).
Table 5 - Complete the table using the total number of Emergency Department (ED) Trauma visits for the reporting year following the NTDS inclusion criteria or your trauma center’s inclusion criteria.

Colored boxes should all match
Admitted Trauma Patients

“Patients that are brought to the ED by EMS, and trigger a beeper activation (both a MAJOR or MINOR activation) with trauma team arrival based on suspected injuries/concerning mechanism or physiology. After their workup the patients are stable enough to be discharged to home from the ED. These patients are not admitted to the hospital, would this count toward the volume criteria?” (Level 1)

If the patients were worked up and stable to be discharged from the Emergency Department and were not admitted to a service (Trauma)/hospital, these patients would not count toward the patient volume requirement. To meet the requirement and complete the online PRQ data tables, we want the number of admitted trauma patients that meet the NTDS Inclusion Criteria or your trauma center’s admission inclusion criteria.
Hybrid Operating Room

“Is access to the Hybrid OR required at a Level I - the Trauma Service and Ortho service already have dedicated Trauma OR's” (Level 1)

There are no requirements regarding access to the hybrid operating room.
“If you do not have a dedicated social worker. What would be a best practice to demonstrate commitment to the trauma program?” (Level 2)

The best practice to demonstrate commitment to the trauma program would be for the Social Worker be made part of the trauma team or at a minimum, provided updates in regard to activities within the trauma program. In addition, the Social Worker should document his/her evaluation in the medical record.
Non-Trauma Admissions versus Non-Surgical Admissions

“Please clarify the difference between Non-Surgical Admissions and Non-Trauma Admissions? What should we be looking to reduce? In regards to Non-Surgical Admissions, what specialty services are considered surgical?” (Level 3)

Non-Trauma admissions are those patients that do not meet the NTDS Inclusion Criteria or your trauma center’s inclusion criteria as a ‘trauma’ admission.

Non-Surgical admissions are those patients that meet NTDS Inclusion Criteria or your trauma center’s as a ‘trauma’ admission, and do not require surgical intervention. Non-Surgical admissions may be admitted to the Trauma, Neurosurgery or Orthopaedic services.
Orange Book Revisions

“For level III's would you expect the ACS to better define the role and requirements for staffing specific to the TPM, data support?” (Level 3)

We expect to define the roles and requirements for staffing at Level I, II and III trauma centers.

In conjunction with the Trauma Surgeons, we are working with nurse partners from the Society of Trauma Nurses (STN). For every chapter undergoing revision, there are two STN nurse partners assigned to the workgroups. These nurses work at Level I, II and III trauma centers.
“On the new Excel research form, what is considered ‘multi-system’? There is also a category for ‘multi-center’.” (Level 1)

The term multicenter and multisystem are used interchangeably. It is defined as collaboration between any two or more trauma centers. The co-/authors must be from the trauma centers involved in the collaboration.
Medical Records

“I am looking for some guidance. I am preparing for our consultative visit and I am getting charts together for the Medical Records review. Do I only pull records from the reporting period? If so, I will not have the required number of charts for each category. Or do I go back as far as I have to get the requested number? If that is the case, I will have to go back several years. For example, to pull 30 deaths, I will need to go back to the middle of 2015. I just want to be sure to do what I should.”

For the onsite visit, the medical records are for the reporting period. If you do not have the requested number of medical records for a specific category(ies), pull what will be available at the time of the visit. If there are medical records that have multiple injuries, do not copy the medical record, place it in the most appropriate category and tag it as a multisystem injury.
"For Level I Pediatric Trauma Centers do you pull the patient charts for only patients less than 15?" (Level 1)

For pediatric verification purposes and completion of the PRQ, only report data for patients who were admitted and captured in your trauma registry under the age of 15. Do not include data for those patients older than 15 years old in the PRQ.

For the onsite review, we recommend pulling medical records for those patients older than 15 years of age. These cases may be tagged as older than 15 years old and/or kept in its own stack.
Site Visit Timeline

“Could you cover another hypothetical timeline? If verification expires on 10/1/21, apply? data year? visit date?” (Level 3)

You have to work backwards:

- Based on your center’s expiration date
- Determine when you would like the visit scheduled
- Submit application 14-15 month in advance from proposed date of visit
- Reporting year is 12 months w/2 month lag from month of scheduled visit
Alternate Pathway Criteria (CD 6-3)

“Non boarded orthopedic surgeon; if cleared for alternate pathway in previous + survey do you have to go through process again?” (Level 2)

If approved in previous site visit, an additional onsite Alternate Pathway review will NOT be required; however, documentation must be provided at the time of the visit for the following:

- A list of 36 hours of verifiable, external trauma-related CME over a 3-year period; equivalent hours in the trauma center’s internal education process; or a combination thereof;
- PI assessment by the TMD to ensure that patient outcomes compare favorably to other members of the trauma panel
Backlog Data

“We have a backlog of data in 2017 but are concurrent in 2018. Will this result in a CD if 2017 isn't completed by our 2019 visit” (Level 1)

For Verification purposes and completing the online PRQ, it would not be a deficiency if the data is concurrent for the reporting year. With this said and based on this instance, it may impact the quality of your data and what is reporting to TQIP.
Pediatric Site Visit

“We are scheduled for a visit 2/19 and now considering Peds verification for same time. Is it too late to do?”

(Level 1)

It is not too late. If you intend to seek pediatric verification at the time of the adult verification visit, please contact us as soon as possible. We will need to update your hospital record and online PRQ, and ensure you have the appropriate members on the review team.
Staff Changes

“How vulnerable is a program if there are multiple staff changes; TPM, TMD, surgeons?” (Level 1)

This will depend on how strong your program is. If the TPM and TMD are both new to the institution and there’s a visit in the very near future, it may pose a challenge to learn how the program functions in that short of time.

Usually if there are staffing changes where the TMD and TPM are both new in their roles, ideally we would recommend a consultation visit.

We have had site visits where a new TMD has been appointed on the spot and usually it is someone that already serves on the trauma panel.
Neuro Interventional Radiology

“For Level II Trauma Center verification, is the facility required to have Neuro Interventional Radiology? Or transfer agreement?” (Level 2)

The ACS does not have requirements in regard to Neuro Interventional Radiology.
CD-Related Questions
**Bypass/Divert (CD 3-6)**

“When there is a lapse in pediatric anesthesia coverage - is this counted as diversion hours or services unavailable (no hours)?” (Level 2)

If there is a lapse in pediatric anesthesia coverage, this would count as diversion hours. The program would need to meet the criteria for diversion as noted below:

- Trauma Surgeon involved in the decision process (CD 3-5);
- Identify when the hospital’s resources are not available or the event of an internal hospital disaster;
- Notify the EMS agency and hospital personnel;
  - Provide status updates
- Notify other trauma centers of divert and/or advisory status;
- **Review occurrences through the PIPS process (< 5%, CD 3-6).**
“Our attendings in pediatric trauma have all done ATLS training. We are a Level 1 Pediatric Trauma Center. Do they need to refresh their credentials formally in an ATLS course before expiration or if they are actively practicing does that meet ACS requirements?” (Level 1)

Members who require current ATLS status:
• Trauma Medical Director
• Physicians who work in the Emergency Department who are not board certified in Emergency Medicine, but who are currently board certified in say Family Practice, Internal Medicine, etc,
• Advance Practice Providers for the Trauma Service and the Emergency Department who are members of the trauma activation team, and evaluate and resuscitate trauma patients

Members who must have taken ATLS at least once:
• Trauma Surgeons
• Physicians who work in the Emergency Department who are board certified in Pediatric/Emergency Medicine
• Advance Practice Providers for the Trauma Service and the Emergency Department who are (or are not) members of the trauma activation team, and do not evaluate and resuscitate trauma patients such as, a Nurse Scribe
OPPE (CD 5-11)

“Does the OPPE for the Ortho & Neurosurgery needs to be completed by the Specialty Liaison? Or is it acceptable if it is done by the Medical Staff and the TMD reviews it?” (Level 2)

“I have a clarifying question from last month’s question. When discussing OPPE, for the specialists (example neurosurgeons) is it ok to have one OPPE for the entire group and evaluate them overall as a group? Or one form with each of their names listed.” (Level 2)

Yes, it is acceptable for the OPPE to be completed by the Med Staff as long as the TMD and specialty Directors have review and signed off on the content.

Each provider must have their own individual OPPE process.
“Can a NP with ATLS’s arrival time to a limited Tier activation count as Trauma Surgeon Arrival time?”

(Level 3)

The NP’s arrival time for a Limited Tier activation cannot count towards the Trauma Surgeon’s response time. With that said, the NPs with current ATLS may be the responder to the Limited Tier activation based on your institutions guidelines; however, there must be guidelines in place for when the Trauma Surgeon is expected to respond at bedside for those patients.
Risk Adjusted Benchmarking Report (CD 15-5)

“How will CD 5-15 be viewed in relation to the risk adjusted benchmark reports being late?” (Level 1)

Receiving or not receiving the TQIP report does not infer a deficiency. If you do not have a current TQIP report, the reviewers will want to know based on previous TQIP reports, how the trauma center is:

- Using TQIP to enhance your current PIPS process;
- Identifying areas for improvement and how it has worked on those areas;
- Sharing your data beyond your trauma team (Specialists, hospital QI, etc.)
Non-Surgical Admissions (NSA) (CD 5-18)

“CD 5-18. Are the TPD and TMD required to review all nonsurgical admissions (NSA) or only the NSAs with an ISS greater than 9?” (Level 2)

For trauma centers that admit more than 10% of trauma patients to a non-surgical service, the PIPS process must review **all** non-surgical admissions.
Non-Surgical Admissions (CD 5-18)

“Please clarify the inclusion criteria for nonsurgical admits (is the 10% AFTER exclusion of falls & surgical consults?)”
(Level 2)

The trauma center will use either the NTDS Inclusion Criteria or your trauma center’s inclusion criteria. If the patient meets the inclusion criteria, it is best to admit to the Trauma Service for the first 24 hours.

The following is an example of managing NSA: 43 year old, fall 10 ft from ladder; small subdural, external abrasions, diabetic:

1. Cleared by EM, admit Medicine (Avoid) → PIPS
2. Cleared by Trauma in ED, admit Medicine/Hospitalist with NS consult (Better)
3. Admit Trauma with NS consult (Best) - OR -
4. Admit Trauma first 24 hours → (Tertiary Exam) acceptable, transfer to Family Physician with NS on consult (Best)
“CD 5-24 How is clinical experience in the care of injured patients defined?” (Level 1)

The ACS does not define ‘clinical experience.’ Qualifications as it relates to clinical experience will be defined by the trauma center.
“30 minute response time example for NSR: In past webinars you stated penetrating injury to head with AMS. Can you please provide your definition of altered mental status?” (Level 1)

Penetrating injury to the head with an altered mental status is defined as, any depression in consciousness (sleepiness, drowsiness, lethargy, coma), or any confusion or disorientation. Basically anything that isn’t normal thinking or level of consciousness.
As far as being board certified, does that include routine trips to the OR? Or is that only for patients emergently going to the OR and the physicians on call? Also, for example, if the only available anesthesiologist (in an emergent situation) is non-board certified, can they start the case and have a board certified anesthesiologist take over before a 30 minute response time?” (Level II)

This criteria was changed shortly after the release of the Resources manual to only requiring the Anesthesiologist liaison be currently board certified.

The criteria has no impact on the other Anesthesiologist who take patients to the operating room for either emergent or non-emergent cases.
Operating Room Staffing (CD 11-14)

“CD 11-14. Does ‘adequately staffed’ include an anesthesiologist if your facility does not utilize CRNAs?” (Level 2)

The composition of the operating room team will vary by institution. This may include, but is not limited to the following: Operating Room Nurse, Scrub Nurse, Surgical Tech, Surgeon, Anesthesiologist, CRNA, etc. Anyone of these team members may begin preparing the room and patient within 15 minutes while waiting for the Anesthesiologist to arrive. If the center does not utilize CRNAs, the Anesthesiologist must be in-house 24 hours a day (CD 11-4).
ICU Patient-to Nurse Ratio (CD 11-66)

“Please clarify nurse patient ratio for ICU holds in the ED - some may be there for greater than 24 hours or longer” (Level 1)

Clarification following discussion with the VRC Chair regarding the July webinar question on the patient-to-nurse ratio of 2:1 in the ICU and whether the intent was meant for patients while in the ICU unit and those waiting for a bed in the Emergency Department. After further discussion, the VRC Chair has determined that the guidelines for the patient-to-nurse ratio for ICU patients while in the ICU and/or in the Emergency Department (waiting for a bed) will be set at each individual trauma center.
Hospice Case (CD 16-6)

“I understand that when a patient is discharged to hospice care I need to include them in my deaths. My question is for the patient that was seen and treated for an ortho injury and discharged to hospice, she returns to the hospital 3 days later after a fall and has a head bleed and is admitted as the family wants to withdrawal hospice. She is discharged the next day, back to hospice. Does she count in my death numbers twice? ”

If the patient was transferred to a Hospice Service within the hospital or a hospice facility, the expectation is that the care leading up to the transfer is evaluated through the PIPS process by the TMD and TPM. If any issues are found, then it can be reviewed at peer review.
Peer Review Meetings (CD 16-15)

“There is a push by some of our liaisons to combine both the trauma operational and peer review meetings. What is appropriate format?” (Level 1)

These meetings should be kept separate as they differ based on requirements.

The purpose of the Multidisciplinary Peer Review meetings which requires attendance (at minimum 50%) by the liaisons (CD 16-15) and minutes, is to improve trauma care by reviewing selected death cases, complications, and sentinel events with objective identification of issues and appropriate responses.

The Operational meeting does not require attendance by the liaisons and is typically attended by hospital and medical staff members. The exact format may be hospital-specific in which it examines trauma-related hospital operations/functions.
“Is it mandatory to have all RNs taking care of trauma patients ‘trauma educated’? We use a lot of travelers with no trauma exp.” (Level 1)

The trauma center must have a mechanism in place to provide trauma-related education to all nurses who are caring for trauma patients. With that said, the ACS does not have a requirement for what education specifically nurses must have. A low percentage of trauma-related education for nurses who care for trauma patients may be cited as an opportunity for improvement.
Alcohol Screening (CD 18-3)

“1.) What is the starting age for the patient for Alcohol Screening for Adult Trauma Centers? I heard 12 but it is not documented anywhere. 2.) Does the screening has to be BAC or it can include other screening tools e.g. CAGE? In other words, the Type II deficiency is for <80%BAC not done of screening not done?” Level 1

In response to question 1, the trauma center will define the starting age to screen trauma patients. Some trauma centers have defined it as early as 12 years of age, but this is not a requirement.

Question 2, the trauma center may use other screening tools such as, CAGE, BAC, etc. The deficiency is not based on the type of tool used to screen patients; however, it is based on the number of admitted trauma patients that did not receive a screening.
Research Alternate Method (CD 19-7)

“Regarding chapter 19 and research was it recently decided that option 2 is no longer available to Level I trauma centers?” (Level 2)

Option 2, as noted on page 146 of the Orange Book, is still available for adult and pediatric Level I Trauma Centers.

We made an update to the questions within the online PRQ so that it aligns with Chapter 19.
CME Board Certification Certificates

“Do we need to show proof of board certification at site visit for revised CME requirement or will dates of cert on PRQ suffice?” (Level 1)

To demonstrate compliance with the change in the CME requirement, the board certification on the appendices for all providers must be current and accurate. In the areas asking for ‘Board Certified… enter the expiration date of when the boards expire or are valid through. The following appendices will be impacted by this change: 1-2, 4-9 and 13-14.
“Please review CME requirements for trauma, orthopedics, anesthesia and ED physicians” (Level 2)

Only the Trauma Medical Director and any surgeons undergoing the Alternate Pathway are required to have 36 hours over a 3 year period (or 12 per year) of external trauma-related CME.

For the Alternate Pathway surgeon, the requirement is 36 hours over a 3 year period (or 12 per year), an equivalent amount of hours under the program’s IEP, or a combination of both.
CME Board Eligible Surgeons and Physicians

“Since we don't have to include CME for any Board Certified Physicians, do we need to include them for Board Eligible physicians?” (Level 2)

Surgeons and Physicians who are board eligible satisfy the CME requirement. In the appendices, note the date of when they completed primary training and list them as ‘Board Eligible.’
Orange Book Revisions

“When is the next edition of the ‘Resources for the Optimal Care of the Injured Patient’ due to be published? After the next edition of the ‘Resources’ book is published, is the continued need for a clarification document anticipated?” (Level 1)

There is no tentative date of when the next Resources manual will be released. With that said, there will be a new PRQ that will have the capability to allow for each standard to have a clarification or the intent defined if you will. For example PRQ question: ‘Is there a trauma surgery published back-up call available (CD 6–6)’? The clarification to that criteria would be, ‘when the attending is encumbered, is there a schedule identifying who is on the trauma surgery back-up call schedule.’
Thanks for your participation!